R590. Insurance, Administration.
R590-89. Unfair Claims Settlement Practices Rule.
R590-89-1. Authority.

This rule is promulgated pursuant to Sections 31A-201(1) and 31A-2-201(3)(a) in which the Commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Section 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to sections 31A-26-301 and 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Section 31A-26-303(4). Section 31A-2-308(1)(a) provides for penalties for any person who violates any insurance statute or rule.

R590-89-2. Purpose.

The business of insurance continues to be one of public trust assumed by persons accepting licenses to operate in this State and inherently includes a duty to treat claimants fairly, equitably and in good faith. The breach of such duty is considered to be an unfair or deceptive business practice and injurious to the insuring public. The purpose of this rule is to respond to the volume of complaints arising from claims settlement practices by affirmatively establishing standards of equity and good faith to guide licensees in the settlement of claims. Furthermore, as the standards are properly followed by all licensees, it should encourage future self-regulation of the insurance industry. It is intended that this rule will help to establish parity between the public and professional insurance licensees and facilitate the prompt and fair settlement of insurance claims.

R590-89-3. Scope.

This rule defines certain minimum standards which, if violated, may constitute unfair claims settlement practices. All agency actions will be conducted pursuant to the Utah Administrative Procedures Act. Penalties for violation of this rule shall be in accordance with Section 31A-2-308, Utah Code. This rule applies to all persons and to all insurance policies, contracts and transactions. Individual agents, brokers, consultants, and adjusters are subject to these standards, as well as other persons herein defined. This rule is not exclusive, and other acts, not herein specified, may also be considered to be violations of the insurance code or other rules. This rule is regulatory in nature and is not intended to create a private right of action.

R590-89-4. Definitions.

A. "Agent" means any individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

B. "Claim" means, for the purpose of this Rule, a request or a demand on an insurer, whether by a first party or a third party, for payment of benefits according to the terms of an insurance policy.

C. "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant;

D. "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract

arising out of the occurrence of the contingency or loss covered by such policy or contract. For the purposes of this Rule, certificate holders of group disability policies are considered to be first party claimants;

E. "General business practice" means a pattern of conduct.

F. "Insurance policy" or "insurance contract" shall mean any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity issued, proposed for issuance, or intended for issuance by any person;

G. "Insurer" means a person who may issue or who does issue any insurance policy or insurance contract within this state, whether or not licensed to do so.

H. "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

I. "Notice of Loss" shall be that notice which is in accordance with policy provisions and insurer practices. "Notice of Loss" shall include "Special Notice of Loss" as defined herein. Notice of loss shall also include a Notice of Default or Notice of Delinquency to mortgage insurers.

J. "Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

K. "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, self-insurer, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, consultants and adjusters.

L. "Proof of Loss" shall mean, reasonable documentation by the insured as to the facts of the loss and the amount of the claim.

M. "Special Notice of Loss" shall mean Notice of Loss required to be given by means other than first class mail, such as by telephone or facsimile, or at times which could be other than during normal business hours.

N. "Specific Disclosure" shall mean notice to the insured by means of policy provisions in boldface type or a separate written notice mailed or delivered to the insured.

O. "Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

R590-89-5. Notice of Loss.

A. Notice of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

B. Notice of Loss may be given by an insured to any appointed agent, authorized adjuster, or other authorized representative of an insurer unless the insurer clearly directs otherwise by means of Specific Disclosure as defined herein.

C. Subject to policy provisions a requirement of written or Special Notice of Loss may be waived by any appointed agent, authorized adjuster, or other authorized representative of the insurer.

D. If Special Notice of Loss is required, the insured shall be advised by Specific Disclosure, as defined herein.

E. Insurance policies shall not require Notice of Loss to be given in a manner which is inconsistent with the actual practice of the insurer. An insurer shall not generally conduct

business on the basis of waivers of right, enforcing the terms of the contract only in exceptional circumstances. For example, if the general practice of the insurer is to accept Notice of Loss by telephone, the policy shall reflect that practice, and not require that the insured furnish "immediate written notice" of loss.

R590-89-6. Proof of Loss.

A. Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule.

B. The requirements of Section 31A-21-312(1)(a) and (b) may be satisfied in practice and do not require that the actual language of the above-noted sections be recited in the policy.

R590-89-7. Unfair Methods, Deceptive Acts and Practices Defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts and practices in the business of insurance, and the commission of which are violations of this rule:

A. Denying or threatening the denial of the payment of claims or rescinding, canceling or threatening the recision or cancellation of coverage under a policy for any reason which is not clearly described in the policy as a reason for such denial, cancellation or rescission.

B. Failing to provide the insured or beneficiary with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial.

C. Compensation by an insurer of its employees, agents or contractors of any amounts which are based on savings to the insurer as a result of denying the payment of claims.

D. Failing to deliver a copy of standards for prompt investigation of claims to the Insurance Department when requested to do so.

E. Refusing to pay claims without conducting a reasonable investigation.

F. Offering first party claimants substantially less than the reasonable value of the claim. Such value may be established by one or more independent sources.

G. Making claim payments to insureds or beneficiaries not accompanied by a statement or explanation of benefits setting forth the coverage under which the payments are being made and how the payment amount was calculated.

H. Failing to pay claims within 30 days of properly executed proof of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance.

I. Refusing payment of a claim solely on the basis of an insured's request to do so unless.

1. the insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim; or

2. the insured is granted the right under the policy of insurance to consent to settlement of claims.

J. Advising a claimant not to obtain the services of an attorney or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim.

K. Misleading a claimant as to the applicable statute of limitations.

L. Requiring an insured to sign a release that extends beyond the occurrence or cause of action that gave rise to the claims payment.

M. Deducting from a loss or claims payment made under one policy those premiums owed by the insured on another policy unless the insured consents.

N. Failing to settle a first party claim on the basis that responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions.

O. Issuing checks or drafts in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer or its insured from total liability.

P. Refusing to provide a written basis for the denial of a claim upon demand of the insured.

Q. Denial of a claim for medical treatment after preauthorization has been given, except in cases where the insurer obtains and provides to the claimant documentation of the pre-existence of the condition for which the preauthorization has been given or if the claimant is not eligible for coverage.

R. Refusal to pay reasonably incurred expenses to an insured when such expenses resulted from a delay, as prohibited by these rules, in claims settlement or claims payment.

S. When an automobile insurer represents both a tort feasor and a claimant:

a. failing to advise a claimant under any coverage that the same insurance company represents both the tort feasor and the claimant as soon as such information becomes known to the insurer;

b. allocating medical payments to the tort feasor's liability coverage before exhausting a claimant's personal injury protection coverage.

T. Failure to pay interest at the legal rate, as provided in Title 15, Utah Code, upon amounts that are overdue under these rules.

R590-89-8. File and Record Documentation.

The insurer's claim files shall be subject to examination by the Commissioner or by his duly appointed designees. Such files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed.

R590-89-9. Misrepresentation of Policy Provisions: Prohibited Acts Applicable to All Insurers.

A. No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented, including loss of use and household services.

B. No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

C. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

R590-89-10. Failure to Acknowledge Pertinent Communications.

A. Every insurer, upon receiving notification of a claim shall, within 15 days, acknowledge the receipt of such notice unless payment is made within such period of time, or unless the insurer has a reason acceptable to the Insurance Department as to why such acknowledgment cannot be made within the time specified.

B. Every insurer, upon receipt of an inquiry from the Insurance Department respecting a

claim shall, within fifteen days of receipt of such inquiry, furnish the Department with a substantive response to the inquiry.

C. A substantive response shall be made within 15 days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

D. Every insurer, upon receiving notification of claim shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

R590-89-11. Standards for Prompt Investigation of Claims.

Every insurer shall complete investigation of a claim within 45 days after notification of claim, unless such investigation cannot reasonably be completed within such time. It shall be the burden of the insurer to establish, by adequate records, that the investigation could not be completed within 45 days of its notification of such claim.

R590-89-12. Minimum Standards for Prompt, Fair and Equitable Settlements Applicable to All Insurers.

A. The insurer shall provide to the claimant a statement of the time and manner in which any claim must be made and the type of proof of loss required by the insurer.

B. Within 30 days after receipt by the insurer of properly executed notice of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot reasonably be completed within that time. If the investigation cannot be completed within 30 days the insurer shall so communicate to the claimant and shall continue to so communicate at least every 30 days until the claim is either paid or denied. No insurer shall deny a claim on the grounds of a specific provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial. Any basis for the denial of a claim shall be noted in the insurer's claim file and must be communicated promptly and in writing to the claimant.

C. Unless otherwise provided by law, an insurer shall promptly pay every valid insurance claim. A claim shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of the loss. Payment shall mean actual delivery or mailing of the amount owed. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice or investigation is overdue if not paid within 30 days. Any payment shall not be deemed overdue when the insurer has reasonable proof to establish that the insurer is not responsible for the payment, notwithstanding that written notice has been furnished to the insurer.

D. If negotiations are continuing for settlement of a claim with a claimant, notice of expiration of statute of limitation or contract time limit shall be given to the claimant at least 60 days before the date on which such time limit may expire.

E. No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

F. Proof of loss requirements may not be unreasonable and should consider all of the circumstances surrounding a given claim.

R590-89-13. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

A. When the insurance policy provides for the adjustments and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(1) The insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by:

(a) The cost of a comparable automobile in the local market area when a comparable automobile is available in the local market area; or

(b) One of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area.

(3) When a first party automobile total loss is settled on a basis which deviates from the methods described in subsections A(1) and A(2) of this section, the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deductions for salvage, must be measurable, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

B. Total loss settlements with a third party claimant shall be on the basis of the market value or actual cost of a comparable automobile at the time of loss. Settlement procedures shall be in accordance with paragraphs (2) and (3) of subsection A.

C. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make a claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

D. Insurers shall not require a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

E. Insurers shall, upon the claimant's request, include the first party claimant's deductible, if any, in subrogation demands initiated by the insurer. Subrogation recoveries may be shared on a proportionate basis with the first party claimant when an agreement is reached for less than the full amount of the loss, unless the deductible amount has been otherwise recovered. The recovery shall be applied first to reimburse the first party claimant for the amount or share of the deductible when the full amount or share of the deductible has been recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense. If subrogation is initiated but discontinued, the insured shall be advised.

F. If an insurer prepares or approves an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. If the insurer prepares an estimate, it shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

G. When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

H. When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

I. Where coverage exists, loss of use payment shall be made to a claimant for the reasonably incurred cost of transportation, or for the reasonably incurred rental cost of a substitute vehicle, including collision damage waiver, during the period the automobile is necessarily withdrawn from service to obtain parts or effect repair, or, in the event the automobile is a total loss and the claim has been timely made, during the period from the date of loss until a reasonable settlement offer has been made by the insurer. The insurer may not refuse to pay for loss of use for the period that the insurer is examining the claim or making other determinations as to the payability of the loss, unless such delay reveals that the insurer is not liable to pay the claim. Loss of use payments shall be an amount in addition to the payment for the value of the automobile.

J. Subject to subsection A and B, an insurer shall fairly and equitably and in good faith attempt to compensate a claimant for all losses incurred under collision or comprehensive coverages. Such compensation shall be based at least, but not exclusively, upon the following standards:

1. An offer of settlement shall not be made exclusively on the basis of useful life of the part or vehicle damaged.

2. An estimate of the amount of compensation for the claimant shall include the actual wear and tear, or lack thereof, of the damaged part or vehicle.

3. Actual cash value shall take into account the cost of replacement of the vehicle and/or the part for which compensation is claimed.

4. An actual estimate of the true useful life remaining in the part or vehicle shall be taken into account in establishing the amount of compensation of a claim.

5. Actual cash value shall include taxes and other fees which shall be incurred by a claimant in replacing the part or vehicle or in compensating the claimant for the loss incurred.

K. An insurer may not demand reimbursement of Personal Injury Protection payments from a first-party insured of payments received by that party from a settlement or judgement against a third party.

R590-89-14. Unfair Claims Settlement Practices Applicable to Automobile Insurance.

The Following acts or practices are defined as unfair claims settlement practices pertaining to automobile insurance:

A. Using as a basis for cash settlement with a claimant an amount which is less than the amount which the insurer would be charged if repairs were made, unless such amount is agreed to by the claimant or provided for by the insurance policy.

B. Refusing to settle a claim based solely upon the issuance or failure to issue a traffic citation by a police agency.

C. If an application for benefits is required by the insurer, failing to provide a section for each coverage under the policy under which the claimant can make a claim.

D. Failing to, in good faith, disclose all coverages, including loss of use, household

services, and any other coverages available to the claimant.

E. Requiring a claimant to use only the insurer's claim service in order to perfect a claim.

F. If the insurer makes a deduction for the salvage value of a total loss retained by the claimant, failing to furnish the claimant with the name and address of the salvage dealer who will purchase the salvage for the amount deducted if so requested by the claimant.

G. Refusing to disclose policy limits when requested to do so by a claimant or claimant's attorney.

H. Using a release on the back of a check or draft which requires a claimant to release the company from obligation on further claims in order to process a current claim when the company knows or reasonably should know that there will be future liability on the part of the insurer.

I. Refusing to use a separate release of claims document rather than one on the back of a check or draft when requested to do so by a claimant.

J. Intentionally offering less money to a first party claimant than the claim is reasonably worth, a practice referred to as "low-balling."

K. Refusing to offer to pay claims based upon the Doctrine of Comparative Negligence without a reasonable basis for doing so.

L. In a bailment situation, imputing the negligence of a permissive user of a vehicle to the owner of the vehicle.

R590-89-15. Penalties.

Subject to the provisions of the Utah Administrative Procedures Act, violators of this rule shall be subject to fine, suspension, or revocation of their insurance license or Certificate of Authority, and/or any other penalties or measures as are determined by the commissioner in accordance with law. Any penalty imposed under this rule shall be commensurate with the violation committed and subject to the following provisions and limitations:

A. Separate and disparate penalties may be assessed insurer, organization and individual persons;

B. Frequency of occurrence and severity of detriment to the public shall be considered in determining a penalty;

C. No license or Certificate of Authority shall be suspended on the basis of a single violation; and

D. No revocation of license or Certificate of Authority shall occur except upon a finding of improper conduct as a general business practice.

R590-89-16. Severability.

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

R590-89-17. Effective Date.

This rule shall take effect on September 14, 1989.

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